LSDVI STUDENT HEALTH CENTER

HEALTH INFORMATION

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN EACH SCHOOL YEAR

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE. Parent/Legal guardian is encouraged to participate in the development of your child's Health Care Plan. Please use additional sheets, if necessary, for further explanation.

School (circle one): **LSD** **LSVI** **Grade:**

Student's Name: Last First M.I.

Student's Date of Birth:	**Sex:** ☐ Male ☐ Female	**State or Country of Birth:**

Pediatrician or primary care provider (PCP) NAME:___________________________________PHONE#:_________________________

Names of additional doctors/health care providers that currently care for your child:
NAME:___________________________________PHONE#:________________________SPECIALTY:_________________________
NAME:___________________________________PHONE#:________________________ SPECIALTY:_________________________
NAME:___________________________________PHONE#:________________________ SPECIALTY:_________________________

Please check the type of health insurance your child has: ☐ None ☐ Private ☐ Medicaid

ATTACH A COPY OF THE FRONT AND BACK OF CURRENT HEALTH INSURANCE CARD.

List hospital of choice: ☐ CLOSEST ☐ NAME OF PREFERRED HOSPITAL:_____________________________

Date of last emergency room visit:

Date of last hospitalization:

Reason for hospitalization:

PART 2: COMPLETE ALL BOXES THAT APPLY TO YOUR CHILD. Parent / Legal guardian is responsible for providing the school with any medication and may be responsible for providing the school with any special food or equipment that the student will require during the school day. Check with the school nurse to obtain correct medication and procedure forms.

IS YOUR CHILD ALLERGIC TO ANYTHING? ☐ **No** ☐ **Yes (if yes, please complete below)**

IS AN EPIPEN PRESCRIBED? ☐ **No** ☐ **Yes**

Allergy Type:

☐ Food (list food(s)):

Reaction:

☐ Insect sting (list insect(s)):

Reaction:

☐ Medications / Other (list):

Reaction:

Asthma: ☐ **No** ☐ **Yes (if yes, please complete below)**

Triggers:

☐ Environmental (i.e., tobacco, dust, pets, pollen, etc.), please list:

☐ Other (list):

Does your child experience asthma symptoms with exercise? ☐ No ☐ Yes

Symptoms:

☐ Chest tightness, discomfort, pain ☐ Difficulty breathing ☐ Coughing ☐ Wheezing ☐ Other: ___________________

Diabetes: ☐ **No** ☐ **Yes (if yes, please complete below)**

Currently prescribed medications and treatments:

☐ Oral medication(s):

☐ Insulin: ☐ Syringe ☐ Pen ☐ Pump

☐ Blood sugar testing: ☐ Frequency:

☐ Glucagon:

Seizures: ☐ **No** ☐ **Yes (if yes, please complete below)**

Type of Seizure:

☐ Absence (staring, unresponsive) ☐ Complex Partial ☐ Generalized Tonic-Clonic (Grand Mal / Convulsive)

☐ Other (explain):

Date of last seizure: Length of seizure:

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Name:______________________________ **DOB:**__________________

OTHER HEALTH CONSIDERATIONS:

☐ Anemia ☐ ADD/ADHD ☐ CMV ☐ Cerebral Palsy ☐Cystic Fibrosis ☐Depression ☐ Digestive disorders
☐ Emotional / Psychological ☐ Skin Disorders ☐Sickle Cell Disease ☐Hemophilia ☐ Heart condition ☐ VP Shunt
☐ Feeding tube ☐Speech Problems ☐Physical Disability ☐ Juvenile Rheumatoid Arthritis ☐ Usher's Syndrome
☐Other (explain)____

Medication(s): ☐**No** ☐**Yes –** List names of all medications:____
____

Special Procedures (must have doctor's order) (i.e., catherization, oxygen, gastrostomy care, tracheostomy care): ☐**No** ☐**Yes**
(explain):____

Special Diet (must have doctor's order) (i.e., blended, soft, low salt, low fat, liquid supplement): ☐**No** ☐**Yes**
(explain): ____

Physical Education/Activity Restriction(s) (must have doctor's order): ☐ **No** ☐**Yes**
(explain):____

Special modifications to classroom or school schedule (must have doctor's order) : ☐ **No** ☐**Yes**
(explain): ____

Are there anticipated frequent absences or hospitalizations? ☐**No** ☐**Yes** (explain):_____________________________

VISION CONDITIONS –
Diagnosis:
Age of onset:
Private eye doctor: ☐No ☐Yes
☐Glasses/contacts (circle one - wears sometimes / always / lost / broken)
☐Prosthetic eye (right / left / both)
☐ Other (explain):___________________________________

HEARING CONDITIONS –
Diagnosis:
Age of onset:
☐Hearing aids (circle one - right/ left/ both) Aided by age:
☐Cochlear implant (circle one - right/ left/ both)
Cochlear Implant date: __________Last mapped:_________
☐Other (explain):____________________________________

Special safety considerations (i.e. special precautions, lifting/positioning, special transportation): ☐**No** ☐**Yes**
(explain): ____

Special assistance with activities of daily living (i.e. toileting, eating, walking): ☐**No** ☐**Yes**
(explain): ____

___________________________________ ______________________
Parent / Legal guardian signature Date

Entered into JCAMPUS on ___/____/____ by __________________________